Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON HOSPITAL FOR SPECIALIZED SURGERY
5445 L BRANCH
HOUSTON TX 77004

Respondent Name
Commerce & Industry Insurance

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-4481-01

MFDR Date Received
June 21, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated June 21, 2010: "INCLUSIVE TO OPPS RATES MEDICARE RATE @200%."

Amount in Dispute: $3057.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response from carrier. Receipt of the medical fee dispute was acknowledged by the carrier on June 28, 2010.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 10, 2009	Outpatient Hospital Services	$3,057.35	$3,057.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 16, 2009
   - 97 – Payment is included in the allowance for another service/procedure
   - 45 – Charges exceed your contracted/legislated fee arrangement
   - 59 – Processed based on multiple or concurrent procedure rules
   - W1 – Workers Compensation State Fee Schedule Adjustment

Explanation of benefits dated November 12, 2009
- 97 – Payment is included in the allowance for another service/procedure
- 45 – Charges exceed your contracted/legislated fee arrangement
- 59 – Processed based on multiple or concurrent procedure rules
- W1 – Workers Compensation State Fee Schedule Adjustment

Explanation of benefits dated January 21, 2010
- A1 – Claim/Service denied
- 45 – Charges exceed your contracted/legislated fee arrangement
- W1 – Workers Compensation State Fee Schedule Adjustment

Explanation of benefits dated April 6, 2010
- A1 – Claim/service denied
- W1 – Workers Compensation State Fee Schedule Adjustment
- 59 – Processed based on multiple or concurrent procedure rules
- 45 – Charges exceed your contracted/legislated fee arrangement

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 30, 2010, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the healthcare provider had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code L8699, date of service 08/10/09, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Per Medicare policy, procedure code 26727, date of service 08/10/09, may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services

provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 26727, date of service 08/10/09, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0062, which, per OPPS Addendum A, has a payment rate of $1,680.82. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,008.49. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $997.40. The non-labor related portion is 40% of the APC rate or $672.33. The sum of the labor and non-labor related amounts is $1,669.73. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line is $1,669.73. This amount multiplied by 200% yields a MAR of $3,339.46.

- Per Medicare policy, procedure code 13160, date of service 08/10/09, may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 13160, date of service 08/10/09, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0137, which, per OPPS Addendum A, has a payment rate of $1,391.57. This amount multiplied by 60% yields an unadjusted labor-related amount of $834.94. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $825.76. The non-labor related portion is 40% of the APC rate or $556.63. The sum of the labor and non-labor related amounts is $1,382.39. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line, including multiple-procedure discount, is $691.20. This amount multiplied by 200% yields a MAR of $1,382.40.

4. The total allowable reimbursement for the services in dispute is $4,721.86. The amount previously paid by the insurance carrier is $1,664.50. The requestor is seeking additional reimbursement in the amount of $3,057.35. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,057.35.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,057.35, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 28, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC

Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.